DISCLOSURE AUTHORIZATION

Claimant's Name (Please Print): Steven A. Leano

I AUTHORIZE: any doctor, physician, healer, health care practitioner, hospital, clinic, other medical facility, professional, or provider of health care, medically related facility or association, medical examiner, pharmacy, employee assistance plan, insurance company, health maintenance organization or similar entity to provide access to or to give the company named below (Company) or the Plan Administrator or their employees and authorized agents or authorized representatives, any medical and nonmedical information or records that they may have concerning my health condition, or health history, or regarding any advice, care or treatment provided to me. This information and/or records may include, but is not limited to: cause, treatment, diagnoses, prognoses, consultations, examinations, tests, prescriptions, or advice regarding my physical or mental condition, or other information concerning me. This may also include, but is not limited to, information concerning: mental illness, psychiatric, drug or alcohol use and any disability, and also HIV related testing, infection, illness, and AIDS (Acquired Immune Deficiency Syndrome), as well as communicable diseases and genetic testing. If my plan administrator sponsors both a disability plan underwritten or administered by Company and a medical plan of any type written by another CIGNA company, the information and records described in this form may also be given to any CIGNA Company which administers such medical or disability benefits for the purpose of evaluating any claim that may be submitted by me or on my behalf for benefits, for evaluating return to employment opportunities, and for administering any feature described in the plan. This information may also be extracted for use in audits or for statistical purposes.

I AUTHORIZE: any financial institution, accountant, tax preparer, insurance company or reinsurer, consumer reporting agency, insurance support organization, Claimant's agent, employer, group policyholder, business associate, benefit plan administrator, family members, friends, neighbors or associates, governmental agency including the Social Security Administration or any other organization or person having knowledge of me to give the Company or the Plan Administrator or their employees and authorized agents, or authorized representatives, any information or records that they have concerning me, my occupation, my activities, employee/employment records, earnings or finances, applications for insurance coverage, prior claim files and claim history, work history and work related activities.

I UNDERSTAND: the information obtained will be included as part of the proof of claim and will be used to determine eligibility for claim benefits, any amounts payable, return to employment opportunities, and to administer any other feature described in the plan with respect to the Claimant. This authorization shall remain valid and apply to all records, information and events that occur over the duration of the claim, but not to exceed 24 months. A photocopy of this form is as valid as the original and I or my authorized representative may request one. I or my representative may revoke this authorization at any time as it applies to future disclosures by writing the Company. The information obtained will not be disclosed to anyone EXCEPT: a) reinsuring companies; b) the Medical Information Bureau, Inc., which operates Health Claim Index (HCI); c) fraud or overinsurance detection bureaus; d) anyone performing business, medical or legal functions with respect to the claim or the plan, including any entity providing assistance to the Company under its Social Security Assistance Program and employers involved in return to employment discussions; e) for audit or statistical purposes; f) as may be required or permitted by law; g) as I may further authorize. A valid authorization or court order for information does not waive other privacy rights.

If my medical information contains information regarding drug or alcohol abuse, I understand that my records may be protected under federal (42 CFR Part 2) and some state laws. To the extent permitted under law, I can ask the party that disclosed information to the Company to permit me to inspect and copy the information it disclosed. I understand that I can refuse to sign this disclosure authorization; however, if I do so, Company may deny my claim for benefits pursuant to the plan. The use and further disclosure of information disclosed hereunder may not be subject to the Health Insurance Portability and Accountability Act (HIPAA).

Signature of Claimant or Claimant's Authorized Representative: [signature] Date: 11/4/04

Relationship, if other than Claimant: _____ Claimant's Social Security Number: 089-44-9648

Company Name: CIGNA Life Insurance Company of New York

PROHIBITION ON RE-DISCLOSURE

If the medical information contains information regarding drug or alcohol abuse, it may be protected under federal law. Federal regulations (42 CFR Part 2) prohibit any person or entity who receives such protected information from the Company from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulation. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of such protected information to criminally investigate or prosecute any alcohol or drug abuse patient.

09/14/04 107486 7701200 CERVICAL SPINE MINIMUM 4 VIEWS Final

Ordered:09/14/2004 Location: COMPRH CARE-HT4
Order time: 0929 Name: ALFANO, STEVEN
MRN: (00000)002284147
RADIOLOGY REPORT. Age: 46 YRS Sex: M DOB:01/14/58
Admitting M.D.:ROACH, KEITH W DR. MD

EXAM DATE:	Accession #:	Exam Ordered:	Order M.D.
09/14/04	01-RA-04-107486	CSP 4 V	ROACH, KEITH W DR. MD

FINDINGS:
Clinical History: Neck pain. Lumbar stenosis.
Technique: Frontal lateral and oblique views of the cervical spine. Five views.
Comparison: None
Findings: Degenerative disk disease with disk space narrowing noted at C6-C7. Uncal-vertebral joint osteophyte narrows the neural foramen at this level greater on the left than the right. Remainder of examination is normal. Alignment is normal and there is no evidence of fracture or dislocation. Regional soft tissues and osseous structures are normal.
IMPRESSION:
Degenerative disk disease with disk space narrowing and osteophyte formation at C6-C7. Left foraminal narrowing secondary to uncal vertebral joint osteophyte formation.
DIAGNOSIS:
01RA04107486
Study interpreted and report approved by: Robert D. Zimmerman M.D.
Electronically signed Diagnostic Imaging Report
14SEP200/ 14SEP2004/ RZ
Exam start / Sign-off / Transcription initials.

Mark Sodders
Case Manager
Disability Management Solutions

Routing D212
12225 Greenville Ave.
Suite 1000 – LB 119
Dallas TX 75243
Telephone 1.800.352.0611 Ext 5693
Facsimile 860-731-3413
Mark.Sodders@cigna.com

November 30, 2004

Steven Alfano
3800 Waldo Avenue
13-G
Bronx, NY 10463

Re: Claimant: Steven Alfano
Policyholder: Weill Medical College
Policy Number: NYK 1972
CIGNA Life Insurance Company of New York

Dear Ms. Alfano:

This letter is in reference to the captioned Long Term Disability claim.

As of this date, we have not received the information requested from you in our November 9, 2004 letter. Please provide us with the following information by December 21, 2004:

1. **The enclosed Supplementary Claim Disability Benefits form.**

You may fax this information to the undersigned at 860-731-3413.

A copy of the original request is enclosed with this notice. If this information has already been sent, please disregard this notice.

In addition, please be advised that, as of January 1, 2005, your Gross Monthly Benefit will be subject to a 3% Cost Of Living Adjustment. Your benefit check for the time period of December 3, 2004 through January 2, 2005, will be for the net amount of $2,282.53. Your new Gross Monthly benefit amount, prior to deductions from Other Benefits, will be $4,674.60 beginning January 1, 2005.

Please refer to the enclosed calculation sheets for details.

Your assistance in providing this information is appreciated and will aid in the prompt handling of the claim.

Sincerely,

Mark Sodders

Disability Benefit Adjustment

Version Date: [illegible]

Date: 11/[illegible]/2004

Claimant Name: Sieno Alfano [illegible]

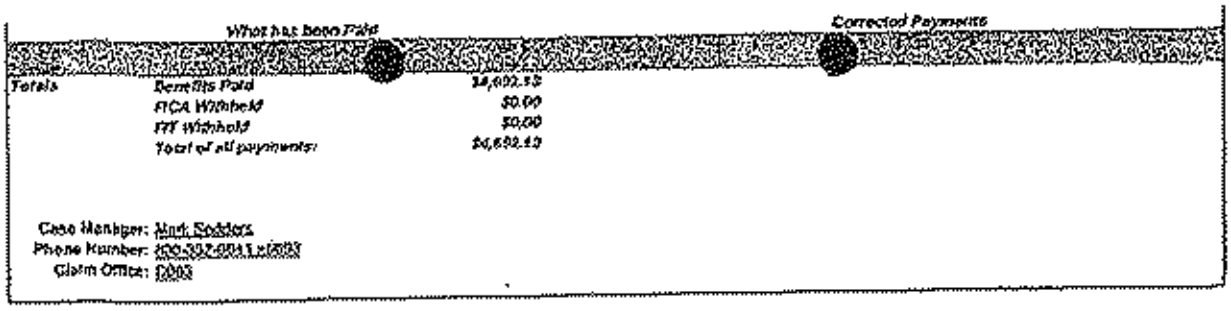
Policyholder: Weill Medical College

Policy Number: NYK 1072

Minimum Benefit: $ 100.00

Reason for Adjustment: 3% COLA Adjustment

What has been Paid				*Corrected Payments*
From: [illegible] Through: [illegible] 28 Days				
Gross Benefit:	$4,225.00 Gross Benefit 28 Days			
Other Benefits:	$1,[illegible] SSDI 28 Days			
	$[illegible] Fam SSDI 28 Days			
Tax Year: 2004				
			Totals this period:	
Net Benefit	$2,121.[illegible]	Kept Monies:	$2,121.[illegible]	
- FICA	$0.00		$0.00	
- FIT	$0.00		$0.00	
Payment Amount:	$2,121.[illegible]		$2,121.[illegible]	
From: [illegible] Through: [illegible] 2 Days				
Gross Benefit:	$[illegible] (COLA Adjustment 2 Days)			
Other Benefits:	$150.[illegible] SSDI 2 Days			
	$50.53 Fam SSDI 2 Days			
Tax Year: 2004				
			Totals this period:	
Net Benefit	$150.64	Kept Monies:	$150.64	
- FICA	$0.00		$0.00	
- FIT	$0.00		$0.00	
Payment Amount:	$150.64		$150.64	
From: [illegible] Through: [illegible] # of Months [illegible]				
Gross Benefit:	$4,[illegible] (New Gross Benefit)			
Other Benefits:	$1,[illegible] SSDI			
	$[illegible] Fam SSDI			
Tax Year: 2005				
			Totals this period:	
Net Benefit	$2,[illegible]	Kept Monies:	$2,[illegible]	
- FICA	$0.00		$0.00	
- FIT	$0.00		$0.00	
Payment Amount:	$2,[illegible]		$2,[illegible]	


What has been Paid
Corrected Payments
Totals
Benefits Paid
FICA Withheld
FIT Withheld
Total of all payments:
$0.00
$0.00
Case Manager: Mark Sodders
Phone Number:
Claim Office: 0003

Task | Contents | Notes (0/0)

Task: General Follow-Up

Start Date: 11/23/2004 Due Date: 11/24/2004

Logs (0)

Details

Name	STEVEN ALFANO	SSN	099-44-9648	DOB	01/14/1958
Account Name	WEILL MEDICAL COLLEGE	Account #	NYK0001972	Incurred Date	06/05/2000
Claim Manager	Mark Sodders	Incident #	513554	Claim Eff Dt-Status	01/21/2003 - Active

Title: flu exp TSA

Comment/Instruction:

referred on 11/09/04
11/19/04 received today. Waiting on APS for COD.

Date: 11/19/2004 11:05 AM User ID: Mark Sodders

Last Changed User: Mark Sodders Last Changed Date: 11/19/2004 11:05 AM

Active Contents

Type	Due Date	Created By	Assigned To	Title
LTD	06/06/2000		Mark Sodders	ALFANO,STEVEN -- 099449648 -- 01/14/1958

Status: Completed Assigned To: Mark Sodders Created: 11/09/2004 11:51 AM

PHYSICAL ABILITY ASSESSMENT

We are evaluating your patient's disability claim in order to determine functional impairment. Please check the boxes corresponding to the patient's level of physical functioning. **Please substantiate your findings with medical documentation. (Failure to provide the requested reports/data may result in delay in claim determinations).**

Patient Name [illegible] Date of Birth _____

Diagnosis(es)/ICD-9 Code [illegible]

Throughout **an 8-hour workday, the patient can tolerate, *with positional changes and meal breaks*, the following activities for the specified durations:**

		Not applicable to diagnosis(es)	Continuously (67-100%) (5.5 + hrs)	Frequently (34-66%) (2.5 - 5.5 hrs)	Occasionally (1-33%) (<2.5 hrs)	Check if supported by objective findings
Sitting:					✓	✓
Standing:					✓	✓
Walking:					✓	✓
Reaching:	Overhead	✓				
	Desk Level	✓				
	Below Waist	✓				
Fine Manipulation:	Right:	✓				
	Left:	✓				
Simple Grasp:	Right:	✓				
	Left:	✓				
Firm Grasp:	Right:	✓				
	Left:	✓				
Lifting:	10 lbs.				✓	
	11-20 lbs.					
	21-50 lbs.					
	51-100 lbs.				✓	
	100+ lbs.					
Carrying:	10 lbs.				✓	
	11-20 lbs.					
	21-50 lbs.					
	51-100 lbs					
	100+ lbs.					

	Not applicable to diagnosis(es)	Continuously (67-100%) (5.5 + hrs)	Frequently (34-66%) (2.5 - 5.5 hrs)	Occasionally (1-33%) (<2.5 hrs)	Check if supported by objective findings
Pushing: (Max. Wt.: 10 lb)				✓	
Pulling: (Max. Wt.: 10 lb)				✓	
Climbing: Regular Stairs				✓	
Regular Ladders				✓	
Balancing:				✓	
Stooping:					
Kneeling:					
Crouching:					
Crawling:					
Seeing:	✓				
Hearing:	✓				
Smell/Taste:	✓				
Environmental Conditions: Exposure to extremes in heat	✓				
Exposure to extremes in cold	✓				
Exposure to wet / humid conditions	✓				
Exposure to vibration	✓				
Exposure to odors / fumes / particles	✓				
Can work around machinery					
Ability to work extended shifts/ overtime:					
Use lower extremities for foot controls:				✓	

Please use this space to elaborate on ANY of the above categories:

Name: Kurt Rose
Medical Specialty: Ortho & Joint
Address: New York NY
Federal ID tax number:

Signature:
Date: 10-7-04
Phone: 212 746 8121

Please include any objective test or narrative if available.
Thank you for your time.

Please return this form in the enclosed addressed envelope.

DISCLOSURE AUTHORIZATION

Claimant's Name (Please Print): STEVEN ALFAND

I AUTHORIZE: any doctor, physician, healer, health care practitioner, hospital, clinic, other medical facility, professional, or provider of health care, medically related facility or association, medical examiner, pharmacy, employee assistance plan, insurance company, health maintenance organization or similar entity to provide access to or to give the company named below (Company) or the Plan Administrator or their employees and authorized agents or authorized representatives, any medical and nonmedical information or records that they may have concerning my health condition, or health history, or regarding any advice, care or treatment provided to me. This information and/or records may include, but is not limited to: cause, treatment, diagnoses, prognoses, consultations, examinations, tests, prescriptions, or advice regarding my physical or mental condition, or other information concerning me. This may also include, but is not limited to, information concerning: mental illness, psychiatric, drug or alcohol use and any disability, and also HIV related testing, infection, illness, and AIDS (Acquired Immune Deficiency Syndrome), as well as communicable diseases and genetic testing. If my plan administrator sponsors both a disability plan underwritten or administered by Company and a medical plan of any type written by another CIGNA company, the information and records described in this form may also be given to any CIGNA Company which administers such medical or disability benefits for the purpose of evaluating any claim that may be submitted by me or on my behalf for benefits, for evaluating return to employment opportunities, and for administering any feature described in the plan. This information may also be extracted for use in audits or for statistical purposes.

I AUTHORIZE: any financial institution, accountant, tax preparer, insurance company or reinsurer, consumer reporting agency insurance support organization, Claimant's agent, employer, group policyholder, business associate, benefit plan administrator, family members, friends, neighbors or associates, governmental agency including the Social Security Administration or any other organization or person having knowledge of me to give the Company or the Plan Administrator or their employees and authorized agents, or authorized representatives, any information or records that they have concerning me, my occupation, my activities, employee/employment records, earnings or finances, applications for insurance coverage, prior claim files and claim history, work history and work related activities.

I UNDERSTAND: the information obtained will be included as part of the proof of claim and will be used to determine eligibility for claim benefits, any amounts payable, return to employment opportunities, and to administer any other feature described in the plan with respect to the Claimant. This authorization shall remain valid and apply to all records, information and events that occur over the duration of the claim, but not to exceed 24 months. A photocopy of this form is as valid as the original and or my authorized representative may request one. I or my representative may revoke this authorization at any time as it applie to future disclosures by writing the Company. The information obtained will not be disclosed to anyone EXCEPT: a)reinsuring companies; b)the Medical Information Bureau, Inc., which operates Health Claim Index (HCI); c)fraud or overinsurance detection bureaus; d)anyone performing business, medical or legal functions with respect to the claim or the plan, including any entity providing assistance to the Company under its Social Security Assistance Program and employers involved in return to employment discussions; e)for audit or statistical purposes; f)as may be required or permitted by law; g) as I may further authorize. A valid authorization or court order for information does not waive other privacy rights.

If my medical information contains information regarding drug or alcohol abuse, I understand that my records may be protected under federal (42 CFR Part 2) and some state laws. To the extent permitted under law, I can ask the party that disclosed information to the Company to permit me to inspect and copy the information it disclosed. I understand that I can refuse to sign this disclosure authorization; however, if I do so, Company may deny my claim for benefits pursuant to the plan. The use and further disclosure of information disclosed hereunder may not be subject to the Health Insurance Portability and Accountability Act (HIPAA).

Signature of Claimant or Claimant's Authorized Representative: [signature] Date: 7/20/04

Relationship, if other than Claimant

Claimant's Social Security Number: 056-44-8640

Company Name:

PROHIBITION ON RE-DISCLOSURE

If the medical information contains information regarding drug or alcohol abuse, it may be protected under federal law. Federa regulations (42 CFR Part 2) prohibit any person or entity who receives such protected information from the Company from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulation. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of such protected information to criminally investigate or prosecute any alcohol or drug abuse patient.

OCT. 20. 2004 1:00PM NYPH 9729921205 212 746 NO. 916 P. 1

Also Mailing Original!

Facsimile Transmission Cover Sheet

CIGNA Group Insurance
Life · Accident · Disability

THIRD REQUEST

Transmit to FAX number	Date	Time	Total number of pages including this sheet
212-746-8127	October 15, 2004	2:00 p.m.	4

Name Dr. Roach	Name Mark Sodders
Company	Department CIGNA Disability Management Solutions
Phone 212-746-2879	Phone 1.800.362.0611 Extension 5693
Address 505 E. 70th St. Ht. 450 New York, NY. 10021	Address 12225 Greenville Avenue Suite 1000, LB 179 Dallas Texas 75243

Comments

RE:	Steven Alfano
DOB:	1/14/58
Policyholder:	Weill Medical College NYK 1972
Underwriting Company:	Life Insurance Company of North America

In order to evaluate your patient's eligibility for Long Term Disability benefits (e.g. lost wage income) we are in need of the following information:

- **A completed Physical Abilities Assessment form (attached).**

We ask that you kindly respond by **10/29/04** to avoid any delay in your patient's claim for lost wages.

Naturally, we will consider a reasonable charge for this medical information. Please include your **tax identification number.** If this request requires a pre-payment, please call me at the phone number above or fax (860.731.2907) a fee request to my attention.

Sincerely,

Mark Sodders

CONFIDENTIALITY NOTICE: If you have received this facsimile in error, please immediately notify the sender by telephone at the number above. The documents accompanying this facsimile transmission contain confidential information. This information is intended only for the use of the individual(s) or entity named above. Thank you for your compliance.

Life Insurance Company of North America
Connecticut General Life Insurance Company
CIGNA Life Insurance Company of New York

[ ] Acknowledgement Requested

To Fax a reply, dial: 860.731.2907

11/19/04

Policy Language - anniversary of disabled
lesser of 10% or CPI-W preceding calendar yr.

ID: 6/6/00
BSD: 12/3/00

06/06/00 - 06/05/01 = Covered Earnings 5,933.32

06/06/01 - 06/05/02 = 3.4% = 6,135.05

06/06/02 - 06/05/03 = 1.3% = 6,214.81

06/06/03 - 06/05/04 = 2.4% = 6,282.29

06/06/04 - 06/05/05 = 1.6% = 6,233.21

80% = 4,986.57

Mark Sodders
Case Manager
CIGNA Disability Management Solutions

CIGNA Group Insurance
Life · Accident · Disability

Routing 212E
12225 Greenville Avenue
Suite 1000 LB 179
Dallas, TX 75243-9382
Telephone 800.352.0611 x5693
Facsimile 860.731.2907
Mark.Sodders@Cigna.com

November 9, 2004

Steven Alfano
3800 Waldo Avenue, 13-G
Bronx, NY 10463

Re: Claimant: Steven Alfano
Policyholder: Weill Medical College
Policy Number: NYK 1972
CIGNA Life Insurance Company of New York

Dear Mr. Alfano:

This letter is in reference to the captioned Long Term Disability claim.

A review of our file reveals the need for updated information. One of the provisions of your contract specifies that you may not be considered totally disabled for any period if you are not under the care of a licensed physician. Please complete the following information and return to this office by November 30, 2004:

- Supplementary Claim Disability Benefits form.

You may fax this information back, attention to the undersigned, to 860-731-2907. Or, a return envelope is enclosed for your convenience.

Your assistance in providing this information is appreciated and will aid in the prompt handling of your claim.

Sincerely,

Mark Sodders

15-2004 14:46 From:CIGNA DALLAS 9729521205 To:1212 746 8127 P.1

Also Mailing Original!

Facsimile Transmission Cover Sheet

THIRD REQUEST

CIGNA Group Insurance
Life · Accident · Disability

To/recipient to FAX number	Date	Time	Total number of pages (including this sheet):
212-746-8127	October 15, 2004	2:00 p.m.	4

Name Dr. Roach	Name Mark Sodders
Company	Department CIGNA Disability Management Solutions
Phone 212-746-2879	Phone 1.800.352.0611 Extension 5693
Address 505 E. 70th St. Ht. 460 New York, NY. 10021	Address 12225 Greenville Avenue Suite 1000, LB 179 Dallas Texas 75243

OCT 2 8 2004
CIGNA DALLAS

Comments

RE:	Steven Alfano
DOB:	1/14/58
Policyholder:	Weill Medical College NYK 1972
Underwriting Company:	Life Insurance Company of North America

In order to evaluate your patient's eligibility for Long Term Disability benefits (e.g. lost wage income) we are in need of the following information:

- **A completed Physical Abilities Assessment form (attached).**

We ask that you kindly respond by **10/29/04** to avoid any delay in your patient's claim for lost wages.

Naturally, we will consider a reasonable charge for this medical information. Please include your **tax identification number.** If this request requires a pre-payment, please call me at the phone number above or fax (860.731.2907) a fee request to my attention.

Sincerely,

Mark Sodders

CONFIDENTIALITY NOTICE: If you have received this facsimile in error, please immediately notify the sender by telephone at the number above. The documents accompanying this facsimile transmission contain confidential information. This information is intended only for the use of the individual(s) or entity named above. Thank you for your compliance.

Life Insurance Company of North America
Connecticut General Life Insurance Company
CIGNA Life Insurance Company of New York

[ ] Acknowledgment Requested

To Fax a reply, dial : 860.731.2907

PHYSICAL ABILITY ASSESSMENT

We are evaluating your patient's disability claim in order to determine functional impairment. Please check the boxes corresponding to the patient's level of physical functioning. **Please substantiate your findings with medical documentation. (Failure to provide the requested reports/data may result in delay in claim determinations).**

Patient Name Steven Alfano Date of Birth

Diagnosis(es)/ICD-9 Code cervical strain

Throughout **an 8-hour workday, the patient can tolerate, *with positional changes and meal breaks*, the following activities for the specified durations:**

		Not applicable to diagnosis(es)	Continuously (67-100%) (5.5 + hrs)	Frequently (34-66%) (2.6 - 5.5 hrs)	Occasionally (1-33%) (<2.5 hrs)	Check if supported by objective findings
Sitting:					✓	✓
Standing:					✓	✓
Walking:					✓	✓
Reaching:	Overhead	✓				
	Desk Level	✓				
	Below Waist	✓				
Fine Manipulation:	Right:	✓				
	Left:	✓				
Simple Grasp:	Right:	✓				
	Left:	✓				
Firm Grasp:	Right:	✓				
	Left:	✓				
Lifting:	10 lbs.				✓	
	11-20 lbs.					
	21-50 lbs.					
	51-100 lbs.					
	100+ lbs.					
Carrying:	10 lbs.				✓	
	11-20 lbs.					
	21-50 lbs.					
	51-100 lbs.					
	100+ lbs.					

	Not applicable to diagnosis(es)	Continuously (67-100%) (5.6 + hrs)	Frequently (34-66%) (2.9 - 5.5 hrs)	Occasionally (1-33%) (<2.5 hrs)	Check if supported by objective findings
Pushing: (Max. Wt.: 10 lb)				✓	
Pulling: (Max. Wt.: 10 lb)				✓	
Climbing: Regular Stairs				✓	
Regular Ladders				✓	
Balancing:				✓	
Stooping:					
Kneeling:					
Crouching:					
Crawling:					
Seeing:	✓				
Hearing:	✓				
Smell/Taste:	✓				
Environmental Conditions:					
Exposure to extremes in heat	✓				
Exposure to extremes in cold	✓				
Exposure to wet / humid conditions	✓				
Exposure to vibration	✓				
Exposure to odors / fumes / particles	✓				
Can work around machinery					
Ability to work extended shifts/ overtime:					
Use lower extremities for foot controls:				✓	

Please use this space to elaborate on ANY of the above categories:

Name: Karl Kount
Medical Specialty: [illegible]
Address: [illegible] NY
Federal ID tax number:

Signature: [signature]
Date: 10/26/04
Phone: 212 746 2871

Please include any objective test or narrative if available.
Thank you for your time.

Please return this form in the enclosed addressed envelope.

DISCLOSURE AUTHORIZATION

Claimant's Name (Please Print): STEVEN ALFAND

I AUTHORIZE: any doctor, physician, healer, health care practitioner, hospital, clinic, other medical facility, professional, or provider of health care, medically related facility or association, medical examiner, pharmacy, employee assistance plan, insurance company, health maintenance organization or similar entity to provide access to or to give the company named below (Company) or the Plan Administrator or their employees and authorized agents or authorized representatives, any medical and nonmedical information or records that they may have concerning my health condition, or health history, or regarding any advice, care or treatment provided to me. This information and/or records may include, but is not limited to: cause, treatment, diagnoses, prognoses, consultations, examinations, tests, prescriptions, or advice regarding my physical or mental condition, or other information concerning me. This may also include, but is not limited to, information concerning: mental illness, psychiatric, drug or alcohol use and any disability, and also HIV related testing, infection, illness, and AIDS (Acquired Immune Deficiency Syndrome), as well as communicable diseases and genetic testing. If my plan administrator sponsors both a disability plan underwritten or administered by Company and a medical plan of any type written by another CIGNA company, the information and records described in this form may also be given to any CIGNA Company which administers such medical or disability benefits for the purpose of evaluating any claim that may be submitted by me or on my behalf for benefits, for evaluating return to employment opportunities, and for administering any feature described in the plan. This information may also be extracted for use in audits or for statistical purposes.

I AUTHORIZE: any financial institution, accountant, tax preparer, insurance company or reinsurer, consumer reporting agency insurance support organization, Claimant's agent, employer, group policyholder, business associate, benefit plan administrator, family members, friends, neighbors or associates, governmental agency including the Social Security Administration or any other organization or person having knowledge of me to give the Company or the Plan Administrator or their employees and authorized agents, or authorized representatives, any information or records that they have concerning me, my occupation, my activities, employee/employment records, earnings or finances, applications for insurance coverage, prior claim files and claim history, work history and work related activities.

I UNDERSTAND: the information obtained will be included as part of the proof of claim and will be used to determine eligibility for claim benefits, any amounts payable, return to employment opportunities, and to administer any other feature described in the plan with respect to the Claimant. This authorization shall remain valid and apply to all records, information and events that occur over the duration of the claim, but not to exceed 24 months. A photocopy of this form is as valid as the original and or my authorized representative may request one. I or my representative may revoke this authorization at any time as it applies to future disclosures by writing the Company. The information obtained will not be disclosed to anyone EXCEPT: a)reinsuring companies; b)the Medical Information Bureau, Inc., which operates Health Claim Index (HCI); c)fraud or overinsurance detection bureaus; d)anyone performing business, medical or legal functions with respect to the claim or the plan, including any entity providing assistance to the Company under its Social Security Assistance Program and employers involved in return to employment discussions; e)for audit or statistical purposes; f)as may be required or permitted by law; g) as I may further authorize. A valid authorization or court order for information does not waive other privacy rights.

If my medical information contains information regarding drug or alcohol abuse, I understand that my records may be protected under federal (42 CFR Part 2) and some state laws. To the extent permitted under law, I can ask the party that disclosed information to the Company to permit me to inspect and copy the information it disclosed. I understand that I can refuse to sign this disclosure authorization; however, if I do so, Company may deny my claim for benefits pursuant to the plan. The use and further disclosure of information disclosed hereunder may not be subject to the Health Insurance Portability and Accountability Act (HIPAA).

Signature of Claimant or Claimant's Authorized Representative: [signature] Date: 7/20/04

Relationship, if other than Claimant

Claimant's Social Security Number: 098-44-9640

Company Name:

PROHIBITION ON RE-DISCLOSURE

If the medical information contains information regarding drug or alcohol abuse, it may be protected under federal law. Federal regulations (42 CFR Part 2) prohibit any person or entity who receives such protected information from the Company from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulation. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of such protected information to criminally investigate or prosecute any alcohol or drug abuse patient.

Message Confirmation Report

OCT-15-2004 02:47 PM FRI

Fax Number : 9729521205
Name : CIGNA DALLAS

Name/Number : 912127468127414431
Page : 4
Start Time : OCT-15-2004 02:46PM FRI
Elapsed Time : 00'56"
Mode : STD ECM
Results : [O.K]

Facsimile Transmission Cover Sheet

THIRD REQUEST

CIGNA Group Insurance
Life · Accident · Disability

Transmit to FAX number	Date	Time	Total number of pages (including this sheet)
212-746-8127	October 15, 2004	2:00 p.m.	4

Name Dr. Rosch	Name Mark Sodders
Company	Department CIGNA Disability Management Solutions
Phone 212-746-2879	Phone 1.800.352.0611 Extension 5693
Address 505 E. 70th St. Ht. 450 New York, NY. 10021	Address 12225 Greenville Avenue Suite 1000, LB 179 Dallas Texas 75243

Comments

RE:	Steven Alfano
DOB:	1/14/58
Policyholder:	Weill Medical College NYK 1972
Underwriting Company:	Life Insurance Company of North America

In order to evaluate your patient's eligibility for Long Term Disability benefits (e.g. lost wage income) we are in need of the following information:

- **A completed Physical Abilities Assessment form (attached).**

We ask that you kindly respond by **10/29/04** to avoid any delay in your patient's claim for lost wages.

Naturally, we will consider a reasonable charge for this medical information. Please include your **tax identification number.** If this request requires a pre-payment, please call me at the phone number above or fax (860.731.2907) a fee request to my attention.

Sincerely,

Mark Sodders

[ ] Acknowledgment Requested

To Fax a reply, dial : 860.731.2907

PHYSICAL ABILITY ASSESSMENT

We are evaluating your patient's disability claim in order to determine functional impairment. Please check the boxes corresponding to the patient's level of physical functioning. **Please substantiate your findings with medical documentation. (Failure to provide the requested reports/data may result in delay in claim determinations).**

Patient Name_____ Date of Birth_____

Diagnosis(es)/ICD-9 Code_____

Throughout **an 8-hour workday, the patient can tolerate, *with positional changes and meal breaks*, the following activities for the specified durations:**

		Not applicable to diagnosis(es)	Continuously (67-100%) (5.5 + hrs)	Frequently (34-66%) (2.5 - 5.5 hrs)	Occasionally (1-33%) (<2.5 hrs)	Check if supported by objective findings
Sitting:						
Standing:						
Walking:						
Reaching:	Overhead					
	Desk Level					
	Below Waist					
Fine Manipulation:	Right:					
	Left:					
Simple Grasp:	Right:					
	Left:					
Firm Grasp:	Right:					
	Left:					
Lifting:	10 lbs.					
	11-20 lbs.					
	21-50 lbs.					
	51-100 lbs.					
	100+ lbs.					
Carrying:	10 lbs.					
	11-20 lbs.					
	21-50 lbs.					
	51-100 lbs					
	100+ lbs.					

	Not applicable to diagnosis(es)	Continuously (67-100%) (5.5 + hrs)	Frequently (34-66%) (2.5 - 5.5 hrs)	Occasionally (1-33%) (<2.5 hrs)	Check if supported by objective findings
Pushing: (Max. Wt.:_____)					
Pulling: (Max. Wt.:_____)					
Climbing: Regular Stairs					
Regular Ladders					
Balancing:					
Stooping:					
Kneeling:					
Crouching:					
Crawling:					
Seeing:					
Hearing:					
Smell/Taste:					
Environmental Conditions: Exposure to extremes in heat					
Exposure to extremes in cold					
Exposure to wet / humid conditions					
Exposure to vibration					
Exposure to odors / fumes / particles					
Can work around machinery					
Ability to work extended shifts/ overtime:					
Use lower extremities for foot controls:					

Please use this space to elaborate on ANY of the above categories:

_____

_____

_____

_____

Name: _____ **Signature:** _____

Medical Specialty: _____ Date: _____

Address: _____ Phone: _____

Federal ID tax number: _____

Please include any objective test or narrative if available.
Thank you for your time.

Please return this form in the enclosed addressed envelope.

Message Confirmation Report

SEP-14-2004 01:26 PM TUE

Fax Number : 9729521205
Name : CIGNA DALLAS

Name/Number : 912127458122741431
Page : 4
Start Time : SEP-14-2004 01:26PM TUE
Elapsed Time : 00'35"
Mode : STD ECM
Results : (O.K)

Facsimile Transmission Cover Sheet

CIGNA Group Insurance
Life · Accident · Disability

Transmit to FAX number	Date	Time	Total number of pages (including this sheet)
212-746-8127	September 19, 2004	2:00 p.m.	4

Name Dr. Keith Roach	Name Mark Sodders
Company	Department CIGNA Disability Management Solutions
Phone 212-746-2879	Phone 1.800.352.0611 Extension 5693
Address 505 E. 70 St. Ht. 450 New York, NY. 10021	Address 12225 Greenville Avenue Suite 1000, LB 179 Dallas Texas 75243

2nd Request

Comments

RE: Steven Alfano

DOB: 1/14/58

2nd Request

In order to evaluate your patient's eligibility for Long Term Disability benefits (e.g. lost wage income), we are in need of the following information:

- **A completed Physical Abilities Assessment form (attached).**

We ask that you kindly respond by 9/28/04 to avoid any delay in your patient's claim for lost wages.

Naturally, we will consider a reasonable charge for this medical information. Please include your **tax identification number.** If this request requires a pre-payment, please call me at the phone number above or fax (860.731.2907) a fee request to my attention.

Sincerely,

Mark Sodders
Case Manager

[ ] Acknowledgment Requested

To Fax a reply, dial : 860.731.2907

505 East 70th Street, HT 406, New York, NY 10021

THE NEW YORK HOSPITAL - CORNELL MEDICAL CENTER

Cornell Internal Medicine Associates

212 746-2500
FAX: 212 746-8165/ 746-3803

RECEIVED
AUG 30 2004
CIGNA DALLAS

DATE: 8/24/04

Patient Name: Steven Alfano

NYH #: 228 41 97

Dear: Records Department

We are in receipt of your request for a copy of medical records for _____. Please note that there is a $ 20.00 fee for this service. Kindly make check payable to Cornell Internal Medicine Associates and remit to the above address.

Sincerely,

Steven Tuffo

for Cornell Internal Medicine Associates

8/30/04
$ 20.00

AUG. 19. 2004 1:38PM CIGNA DALLAS NO. 334 P. 1

Facsimile Transmission Cover Sheet

Medical records - # 238 4147

CIGNA Group Insurance
Life - Accident - Disability

Transmit to FAX number	Date	Time	Total number of pages (including this sheet)
212-746-8127	August 19, 2004	2:00 p.m.	4

Name Dr. Keith Roach	Name Mark Sodders
Company	Department CIGNA Disability Management Solutions
Phone 212-746-2879	Phone 1.800.352.0611 Extension 5693
Address 505 E. 70 St. HT. 450 New York, NY. 10021	Address 12225 Greenville Avenue Suite 1000, LB 179 Dallas Texas 75243

Comments

RE: Steven Alfano

DOB: 1/14/58

In order to evaluate your patient's eligibility for Long Term Disability benefits (e.g. lost wage income), we are in need of the following information:

- **A completed Physical Abilities Assessment form (attached).**
- **Copies of your progress notes, including diagnostic test and lab results, from 1/1/02 to the present.**

We ask that you kindly respond by 9/2/04 to avoid any delay in your patient's claim for lost wages.

Naturally, we will consider a reasonable charge for this medical information. Please include your **tax identification number.** If this request requires a pre-payment, please call me at the phone number above or fax (860.731.2907) a fee request to my attention.

Sincerely,

Mark Sodders
Case Manager

[ ] Acknowledgment Requested

To Fax a reply, dial: 860.731.2907

PATIENT INFORMATION SHEET

Steven Alfano
3800 Waldo Ave #13G
Bronx, NY 10463

HOME 718-884-2067
OFFICE (212)746-1038

EMERGENCY CONTACT
NAME Eva Alfano
PHONE 718-884-2067

SOC. SEC.	[illegible]	SEX	DATE OF BIRTH	PLACE OF BIRTH	MARITAL STATUS: M	W	D	S
099-44-9648	228-41-47	M	01/14/1958		X			

SPOUSE'S NAME: Eva Alfano

INS. CO. NAME (Primary): US Healthcare
PLAN # / GROUP #: JJF02010

INS. CO. NAME (Secondary):
PLAN # / GROUP #:

Diagnosis

ICD 780.57 SLEEP APNEA NEC/NOS [illegible]
ICD V70.0 GENERAL MEDICAL EXAM NEC [illegible]
ICD 782.1 NONSPECIF SKIN ERUPT NEC [illegible]
ICD 843.9 SPRAIN HIP THIGH NEC [illegible]
ICD [illegible] [illegible]
ICD 520.9 TOOTH DEVEL/ERUPT DIS NOS [illegible]
ICD 311. DEPRESSIVE DISORDER NEC [illegible]
ICD 213.7 BEN NEO LONG BONES [illegible]
ICD V72.84 PREOP EXAMINATION NOS [illegible]
ICD 724.02 SPINAL STENOSIS-LUMBAR [illegible]
ICD 724.00 SPINAL STENOSIS NOS [illegible]
ICD 600. HYPERPLASIA OF PROSTATE [illegible]
ICD 535.00 GASTRITIS NEC/NOS [illegible]
ICD 535.50 GASTRITIS/DUODENITIS NOS [illegible]
ICD 735.? ACQ DEFORMITY OF TOE NOS [illegible]
ICD 681.9 CELLULITIS OF DIGIT NOS [illegible]
ICD 716.94 ARTHROPATHY NOS-HAND [illegible]
ICD 346.00 CLASSIC MIGRAINE NOT INTRACT [illegible]
ICD 490. BRONCHITIS NOS [illegible]
ICD 784.0 HEADACHE [illegible]
ICD 278.00 OBESITY NOS [illegible]
ICD E929.0 LATE EFF MOTOR VEHIC ACCID [illegible]
ICD 305.11 TOBACCO ABUSE-CONTINUOUS [illegible]
ICD 726.10 ROTATOR CUFF SYND NEC [illegible]
ICD 478.? UPPER RESP DIS NEC [illegible]
ICD 346.0 CLASSICAL MIGRAINE [illegible]
ICD 401.9 HYPERTENSION NOS [illegible]
ICD 716.17 TRAUMA ARTHROPATHY-ANKLE [illegible]
ICD 727.01 GANGLION OF JOINT [illegible]
ICD 462. ACUTE PHARYNGITIS [illegible]
ICD 272.0 [illegible]
ICD 401. ESSENTIAL HYPERTENSION [illegible]
ICD 686.9 LOCAL SKIN INFECTION NOS [illegible]
ICD 079.99 VIRAL INFECTION NOS [illegible]

Medication

TRIAMCINOLONE 0.1% CREAM / apply bid
LISINOPRIL 20MG TABLET / 1 tab po qd
ZESTRIL 20MG TABLET / 1 po qd
PREVACID 30MG CAPSULES / 1 po qd
IMITREX NASAL SPRAY 20MG/SPRAY / 1 spray intranasally prn
IMITREX 50MG TABLET / 1-2 tabs with onset of migraine
ASPIRIN 81MG TABLET EC / 1 po qd
VIOXX 50MG TABLET / 1 tab po qd
OXYCONTIN 40MG TABLETS / 1 tab po tid

ALLERGIES

THE NEW YORK HOSPITAL-CORNELL MEDICAL CENTER

Steven Alfano
NYH # 228-41-47
01/18/02 00:00

CORNELL INTERNAL MEDICINE ASSOCIATES

Patient Name: ALFANO, STEVEN
History #: 2284147
Accession #: 98374556
Soc Security: 099449648
Date of Birth: 01/14/58
Sex: M
Ordered by:
Specimen Date: 01/18/2002 00:00
Report Date: 01/19/2002 08:18
Status: Final

COMP METABOLIC PANEL

ALT	33	U/L	2-60
AST	19	U/L	2-50
ALKALINE PHOSPHATASE	107	U/L	20-125
A/G RATIO	1.6		0.8-2.0
GLOBULIN,CALCULATED	2.8	g/dL	2.2-4.2
ALBUMIN	4.5	g/dL	3.5-4.9
PROTEIN,TOTAL	7.3	g/dL	6.0-8.3
CALCIUM	9.6	mg/dL	8.5-10.4
BUN/CREATININE RATIO	15.5		6.0-25.0
CREATININE	1.1	mg/dL	0.5-1.4
UREA NITROGEN	17	mg/dL	7-25
CARBON DIOXIDE	22	mmol/L	21-33
CHLORIDE	103	mmol/L	98-110
POTASSIUM	4.2	mmol/L	3.5-5.3
GLUCOSE,FASTING		mg/dL	65-109

Glucose was performed on the gray-top tube that we received with your chem-screen order. If you have any questions or concerns, please call our client services department at 800-631-1390.

SODIUM	142	mmol/L	135-146
POTASSIUM	4.2	mmol/L	3.5-5.3
CHLORIDE	103	mmol/L	98-110
CARBON DIOXIDE	22	mmol/L	21-33
UREA NITROGEN	17	mg/dL	7-25
CREATININE	1.1	mg/dL	0.5-1.4
BUN/CREATININE RATIO	15.5		6.0-25.0
CALCIUM	9.6	mg/dL	8.5-10.4
PROTEIN,TOTAL	7.3	g/dL	6.0-8.3
ALBUMIN	4.5	g/dL	3.5-4.9
GLOBULIN,CALCULATED	2.8	g/dL	2.2-4.2
A/G RATIO	1.6		0.8-2.0
BILIRUBIN,TOTAL	0.45	mg/dL	0.20-1.50
ALKALINE PHOSPHATASE	107	U/L	20-125
AST	19	U/L	2-50
ALT	33	U/L	2-60
PTT	30.9	Seconds	22.0-34.0
PROTHROMBIN TIME			
INR	0.93	Ratio	0.90-1.10

No Anticoagulant, Normal 0.9 - 1.1
Oral Anticoagulant, Standard Dose 2.0 - 3.0
Oral Anticoagulant, High Dose 2.5 - 3.5

GLUCOSE	101	mg/dL	65-125

THE NEW YORK HOSPITAL-CORNELL MEDICAL CENTER

65104

CORNELL INTERNAL MEDICINE ASSOCIATES

Steven Alfano
NYH # 228-41-47
01/18/02 00:00
Page 2

The glucose reference range is based on a non-fasting state.

CBC W/ DIFF & PLT

WBC	7.2	Thous/mcL	3.8-10.6
RBC	5.10	Mil/mcL	4.20-5.80
HEMOGLOBIN	15.2	g/dL	13.2-17.1
HEMATOCRIT	44.1	%	38.5-50.0
MCV	86.5	fL	80.0-100.0
MCH	29.8	pg	27.0-33.0
MCHC	34.4	g/dL	32.0-36.0
RDW	13.2	%	11.0-15.0
PLATELET COUNT	267	Thous/mcL	140-400
MPV	8.2	%	7.5-11.5
TOTAL NEUTROPHILS,%	66.4	%	
TOTAL LYMPHOCYTES,%	24.0	%	
MONOCYTES,%	6.1	%	
EOSINOPHILS,%	2.8	%	
BASOPHILS,%	0.7	%	
NEUTROPHILS,ABSOLUTE	4781	cells/mcL	1500-7800
LYMPHOCYTES,ABSOLUTE	1728	cells/mcL	850-3900
MONOCYTES,ABSOLUTE	439	cells/mcL	200-950
EOSINOPHILS,ABSOLUTE	202	cells/mcL	50-550
BASOPHILS,ABSOLUTE	50	cells/mcL	0-200

DIFFERENTIAL

An instrument differential was performed.
Please note new reference range

URINALYSIS,COMPLETE

COLOR	Yellow		Yellow
APPEARANCE	Clear		Clear
GLUCOSE,QL	Negative	mg/dL	Negative
BILIRUBIN	Negative		Negative
KETONES	Negative	mg/dL	Negative
SPECIFIC GRAVITY	1.030		1.001-1.030
BLOOD	Negative		Negative
PH	7.0		5.0-8.0
PROTEIN,TOTAL,QL	30 (1+)	mg/dL	Negative
NITRITE	Negative		Negative
LEUKOCYTE ESTERASE	Negative		Negative
SQUAMOUS EPITHELIAL CELLS	3-5	/hpf	0-5/hpf
WBC	0-2	/hpf	0-3/hpf
BACTERIA	None	/hpf	None
RBC	0-2	/hpf	0-2/hpf
MUCUS	Trace	/lpf	

THE NEW YORK HOSPITAL-CORNELL MEDICAL CENTER

45104

CORNELL INTERNAL MEDICINE ASSOCIATES

Steven Alfano
NYH # 228-41-47
01/18/02 08:39

Progress Note: Steven Alfano / January 18, 2002

CIMA/GMC Preoperative Evaluation
Requested by: Dr. Michael Alexiades
Referring Physician's address/telephone #: 159 E 74th St., New York
fax 212 439 6855
Planned surgery: arthroscopic shoulder surgery, decompression
Surgery date: 1/28/02

HPI: 44 year old man with R shoulder separation, operated on before for rotator cuff tear, now for arthroscopic decompression. Major complaint is pain, limitation of movement.

PMH: severe spinal stenosis - L5-S1
HTN - good control
headaches - relieved by imitrex

Coronary artery disease: none
Diabetes mellitus requiring therapy other than diet: never
COPD: no diagnosis, no symptoms
Asthma: none

PSH: previous shoulder surgery, tonsils, soft palate reduction for sleep apnea

Fhx: HTN, no CAD

Shx: lives with wife, 2 children
Work: trying to get disability, unable to work secondary to back pain
Relationships: lives with wife, stressed about financial issues, health concern
Cigarette use: 30 pack-years
Alcohol: rare
Drugs: no

Health maintenance:
Immunizations:
Last Td: doesn't remember
Flu vaccine: doesn't want
Pneumovax: not indicated
PPD: not indicated

Current Medications: vioxx 50 qd
lisinopril 10 qd
prevacid 30 q HS
ASA 81 mg qd
imitrex nasal spray 20

Allergies:
codeine - nausea

Review of Systems:

THE NEW YORK HOSPITAL-CORNELL MEDICAL CENTER

45104

CORNELL INTERNAL MEDICINE ASSOCIATES

Steven Alfano
NYH # 228-41-47
01/18/02 08:39
Page 2

Problems with anesthesia:never
Bleeding problems:none
Exercise: limited by spinal stenosis, limited by back pain, weakness in leg
Blocks walked before needing to rest: <1
Flights of steps climbed before needing to rest: 1
Reason for stopping: loss of strength in legs
Pulm: no problems
Card: no chest discomfort or palpitations
GI: constipation
GU: urinary retention, evaluated by urology - not felt to need treatment

Objective:

BP Right: 140/104 Left: 140/160 Pulse: 88 Wt: 298 Ht: 6'3"
HEENT: PERRL, EOMI w/out nystagmus, discs flat B, no H/E.
OP,TM's and nares clr, no sinus tenderness.
Neck: no LN, no thyromegaly/nodules, carotids 2+B, no bruits.
Lungs and Chest: C'FA and P. No axillary or SC LN.
Cor: PMI nonenlarged, nondisplaced, RRR s1x2, no m/g/r.

Back: no spinous tenderness or scoliosis. No CVAT.
Abd: BS active, NT, ND, no HSM.
Rectal:
Lymphatics: No axillary, supraclavicular, or inguinal LAN.
Ext: DP 2+ B, no edema.
M/S: moderate R shoulder impingement
Neuro: Nonfocal. Strength 5/5 B UE and LE. DTR's 2+ throughout
Skin: No rashes or dysplastic nevi.
GU: testes NL size, no masses, no scrotal masses, no inguinal hernia B.

Data (as clinically indicated):
Chemistry battery:
CBC:
PT/PTT:
ECG:
Chest X-ray:
Stress test: not indicated

Impression:
low risk for planned procedure

Recommendations:

Keith Roach, MD

THE NEW YORK HOSPITAL-CORNELL MEDICAL CENTER

45184

CORNELL INTERNAL MEDICINE ASSOCIATES

Steven Alfano
NYH # 228-41-47
02/12/02 14:09

Progress Note: Steven Alfano / February 12, 2002

Subjective: 44 year old man with
spinal stenosis
needs evaluation for social security

Objective:

BP 130/90 P 88 bpm Wt 300 lbs Height 6ft 3in
quads 4/5
+ SLR bilaterally
nl sensation
decreased L patellar reflex

Current Medications:

TRIAMCINOLONE 0.1% CREAM / apply bid
VIOXX 50MG TABLET / 1 tab po qd
CELEXA 20MG TABLET / 1 po qd
ZESTRIL 20MG TABLET / 1 po qd
PREVACID 30MG CAPSULES / 1 po qd
IMITREX NASAL SPRAY 20MG/SPRAY / 1 spray intranasally prn
IMITREX 50MG TABLET / 1-2 tabs with onset of migrain
ASPIRIN 81MG TABLET EC / 1 po qd

Allergies:

Impression:

Plan:
forms filled out
f/u with surgery prn

RTC

Keith Roach, MD

THE NEW YORK HOSPITAL-CORNELL MEDICAL CENTER

45104

CORNELL INTERNAL MEDICINE ASSOCIATES

Steven Alfano
NYH # 228-41-47
05/23/02 12:29

HSS

MRI LOWER EXTREMITY

Dr. Michael Alexiades

IMPRESSION:

Magnetic resonance imaging of the right hip demonstrating superficial cartilage loss over the hip joint, borderline acetabular dysplasia and a torn, hyperplastic and degenerated anterior acetabular labrum.

There is a marrow replacement process affecting the left femur which overall has a non-aggressive appearance. Differential possiblities are noted, as above.

Dictated by Hollis Potter M.D.

THE NEW YORK HOSPITAL-CORNELL MEDICAL CENTER

Steven Alfano
NYH # 228-41-47
06/05/02 00:00

CORNELL INTERNAL MEDICINE ASSOCIATES

Patient Name: ALFANO, STEVEN
History #: 2284147
Accession #: 43218721
Soc Security: 089449648
Date of Birth: 01/14/58
Sex: M
Ordered by:
Specimen Date: 06/05/2002 00:00
Report Date: 06/06/2002 02:18
Status: Final

COMP METABOLIC PANEL

GLUCOSE,FASTING		mg/dL	65-109

Glucose was performed on the gray-top tube that we received with your chem-screen order. If you have any questions or concerns, please call our client services department at 800-631-1390.

SODIUM	141	mmol/L	135-146
POTASSIUM	4.2	mmol/L	3.5-5.3
CHLORIDE	103	mmol/L	98-110
CARBON DIOXIDE	22	mmol/L	21-33
UREA NITROGEN	19	mg/dL	7-25
CREATININE	1.1	mg/dL	0.5-1.4
BUN/CREATININE RATIO	17.3		6.0-25.0
CALCIUM	9.6	mg/dL	8.5-10.4
PROTEIN,TOTAL	7.4	g/dL	6.0-8.3
ALBUMIN	4.7	g/dL	3.5-4.9
GLOBULIN,CALCULATED	2.7	g/dL	2.2-4.2
A/G RATIO	1.7		0.8-2.0
BILIRUBIN,TOTAL	0.73	mg/dL	0.20-1.50
ALKALINE PHOSPHATASE	120	U/L	20-125
AST	21	U/L	2-50
ALT	36	U/L	2-60
PTT	32.9	Seconds	22.0-34.0
PROTHROMBIN TIME			
INR	0.95	Ratio	0.90-1.10

No Anticoagulant, Normal 0.9 - 1.1
Oral Anticoagulant, Standard Dose 2.0 - 3.0
Oral Anticoagulant, High Dose 2.5 - 3.5

GLUCOSE	102	mg/dL	65-125

The glucose reference range is based on a non-fasting state.

CBC W/ DIFF & PLT

WBC	7.5	Thous/mcL	3.8-10.8
RBC	5.28	Mill/mcL	4.20-5.80
HEMOGLOBIN	15.5	g/dL	13.2-17.1
HEMATOCRIT	44.8	%	38.5-50.0
MCV	84.8	fL	80.0-100.0
MCH	29.4	pg	27.0-33.0
MCHC	34.7	g/dL	32.0-36.0
RDW	12.4	%	11.0-15.0
PLATELET COUNT	237	Thous/mcL	140-400
MPV	8.3	%	7.5-11.5
TOTAL NEUTROPHILS,%	57.8	%	
TOTAL LYMPHOCYTES,%	22.9	%	

THE NEW YORK HOSPITAL-CORNELL MEDICAL CENTER

Steven Alfano
NYH # 228-41-47
06/05/02 00:00
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CORNELL INTERNAL MEDICINE ASSOCIATES

MONOCYTES,%	6.6	%	
EOSINOPHILS,%	2.6	%	
BASOPHILS,%	0.1	%	
NEUTROPHILS,ABSOLUTE	5153	Cells/mcL	1900-7800
LYMPHOCYTES,ABSOLUTE	1740	Cells/mcL	850-3900
MONOCYTES,ABSOLUTE	502	Cells/mcL	200-950
EOSINOPHILS,ABSOLUTE	198	Cells/mcL	50-550
BASOPHILS,ABSOLUTE	8	Cells/mcL	0-200

DIFFERENTIAL
An instrument differential was performed.

URINALYSIS,COMPLETE

COLOR	Dark Yellow		Yellow
APPEARANCE	Clear		Clear
GLUCOSE,QL	Negative	mg/dL	Negative
BILIRUBIN	Negative		Negative
KETONES	Negative	mg/dL	Negative
SPECIFIC GRAVITY	1.035 H		1.001-1.030
BLOOD	Negative		Negative
PH	6.0		5.0-8.0
PROTEIN,TOTAL,QL	30 (1+)	mg/dL	Negative
NITRITE	Negative		Negative
LEUKOCYTE ESTERASE	Negative		Negative
SQUAMOUS EPITHELIAL CELLS	3-5	/hpf	0-5
WBC	0-2	/hpf	0-3
BACTERIA	None	/hpf	None
RBC	None	/hpf	0-2

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CORNELL INTERNAL MEDICINE ASSOCIATES

Steven Aliano
NYH # 228-41-47
06/11/02 17:58

Progress Note: Steven Aliano / June 11, 2002

Subjective: 44 year old man with
preoperative visit - no changes since last visit 1/02

femur lesion - reassured by orthopaedic oncologist
dx LSMFT (? liposclerosing myxofibrous tumor)

depression - feeling better with benign diagnosis above

erectile dysfunction - also contributing to depression

Objective:

BP 124/84 P 88 BPM Wt 298 LBS Height 6FT 3IN

HEENT: PERRL, EOMI w/out nystagmus, discs flat B, no H/E.
OP,TM's and nares clr, no sinus tenderness.
Neck: no LN, no thyromegaly/nodules, carotids 2+B, no bruits.
Lungs and Chest: CTA and P. No axillary or SC LN.
Cor: PMI unenlarged, nondisplaced, RRR s1s2, no m/g/r.

Back: no spinous tenderness or scoliosis. No CVAT.
Abd: BS active, NT, ND, no HSM.
Rectal:
Lymphatics: No axillary, supraclavicular, or inguinal LAN.
Ext: DP 2+ B, no edema.
M/S: moderate R shoulder impingement
Neuro: Nonfocal. Strength 5/5 B UE and LE. DTR's 2+ throughout.
Skin: No moles or dysplastic nevi.
GU: testes NL size, no masses, no scrotal masses, no inguinal hernia B.

Current Medications:

VICODIN 5/500 TABLET / 1 tab po q 4 h prn
TRIAMCINOLONE 0.1% CREAM / apply bid
VIOXX 50MG TABLET / 1 tab po qd
CELEXA 20MG TABLET / 1 po qd
ZESTRIL 20MG TABLET / 1 po qd
PREVACID 30MG CAPSULES / 1 po qd
IMITREX NASAL SPRAY 20MG/SPRAY / 1 spray intranasally prn
IMITREX 50MG TABLET / 1-2 tabs with onset of migraine
ASPIRIN 81MG TABLET EC / 1 po qd

Allergies:

Impression:

Plan:
low risk for planned surgery

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CORNELL INTERNAL MEDICINE ASSOCIATES

Steven Alfano
NYH # 228-41-47
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ED
New medications: VIAGRA 50MG TABLET/ 1 tab po 1-2 h a intercourse

tobacco use
WELLBUTRIN SR 150MG TABLET/ 1 tab po bid
may have benefit in depression

RTC

Keith Roach, MD

THE NEW YORK HOSPITAL-CORNELL MEDICAL CENTER

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CORNELL INTERNAL MEDICINE ASSOCIATES

Steven Alfano
NYH # 228-41-47
08/08/02 13:53

HSS
May 6, 2002

Examination of the Right Hip
and Left Hip and Proximal Femur

IMPRESSION:

Large non-aggressive bony lesion expands and remodels the proximal femur from the femoral neck throught the proximal shaft and has matrix calcification, compatible with a chondral lesion. Bone scan is recommended to assess activity of the lesion. Chondrosarcoma is in the differential.

L. Daniel Neistadt, MD
ms

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CORNELL INTERNAL MEDICINE ASSOCIATES

Steven Alfano
NYH # 228-41-47
09/27/02 15:48

Progress Note: Steven Alfano / September 27, 2002

Subjective: 44 year old man with
low back pain - got social security disability

femur lesion - reassured by orthopaedic oncologist
dx LSMFT (? liposclerosing myxofibrous tumor)

depression - feeling better with benign diagnosis above
doing better with Wellbutrin

erectile dysfunction - also contributing to depression
got prescription

quit smoking

hernia
c/o pain under R testicle
worse after sex

hip pain - L sided - only once

HTN - on Zestril
Objective:

BP 130/90 hp P 80 bpm Wt 293 lbs Height 6FT 3IN
small bulging, no frank herniation

Current Medications:

VIAGRA 50MG TABLET / 1 tab po 1-2 h a intercourse
WELLBUTRIN SR 150MG TABLET / 1 tab po bid
VICODIN 5/500 TABLET / 1 tab po q 4 h prn
TRIAMCINOLONE 0.1% CREAM / apply bid
VIOXX 50MG TABLET / 1 tab po qd
CELEXA 20MG TABLET / 1 po qd
ZESTRIL 20MG TABLET / 1 po qd
PREVACID 30MG CAPSULES / 1 po qd
IMITREX NASAL SPRAY 20MG/SPRAY / 1 spray intranasally prn
IMITREX 50MG TABLET / 1-2 tabs with onset of migrain
ASPIRIN 81MG TABLET EC / 1 po qd

Allergies:

Impression:

Reassured re hernia

depression - better

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CORNELL INTERNAL MEDICINE ASSOCIATES

back pain - pt plans to get back surgery eventually

Refilled: WELLBUTRIN SR 150MG TABLET / 1 tab po bid
VICODIN 5/500 TABLET / 1 tab po q 4 h prn

RTC

Keith Reich, MD

THE NEW YORK HOSPITAL-CORNELL MEDICAL CENTER

CORNELL INTERNAL MEDICINE ASSOCIATES

Steven Alfano
NYH # 228-41-47
12/11/02 00:00

Patient Name: ALFANO, STEVEN
History #: 2284147
Accession #: 90110627
Soc Security: 099449648
Date of Birth: 01/14/58
Sex: M
Ordered by:
Specimen Date: 12/11/2002 00:00
Report Date: 12/14/2002 12:36
Status: Final

TESTOSTERONE,TOT & FREE				
TESTOSTERONE,%,FREE		2.8 H	Percent	1.0-2.7
TESTOSTERONE,FREE	93.2		pg/mL	50.0-210.0
TOTAL TESTOSTERONE	336		ng/dL	260-1000

THE NEW YORK HOSPITAL-CORNELL MEDICAL CENTER

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CORNELL INTERNAL MEDICINE ASSOCIATES

Steven Alfano
NYH # 228-41-47
12/11/02 14:04

Progress Note: Steven Alfano / December 11, 2002

Subjective: 44 year old man with
noted mass in mouth

low back pain - got social security disability
taking Vioxx, ibuprofen, Vicodin

femur lesion - reassured by orthopedic oncologist
dx LSMFT (? liposclerosing myxofibrous tumor)

depression - feeling better with benign diagnosis above
doing better with Wellbutrin

erectile dysfunction - also contributing to depression
got prescription

quit smoking

hernia
c/o pain under R testicle
worse after sex

hip pain - L sided - only once
R sided labral tear

HTN - on Zestril

SH: did get disability
financially doing much better

Objective:

BP 136/88 P 92bpm RR 12 Wt 283.5lbs Height 6FT 3IN
looks like root of wisdom tooth - supposedly all removed

Current Medications:

VIAGRA 50MG TABLET / 1 tab po 1-2 h a intercourse
WELLBUTRIN SR 150MG TABLET / 1 tab po bid
VICODIN 5/500 TABLET / 1 tab po q 4 h prn
TRIAMCINOLONE 0.1% CREAM / apply bid
VIOXX 50MG TABLET / 1 tab po qd
CELEXA 20MG TABLET / 1 po qd
ZESTRIL 20MG TABLET / 1 po qd
PREVACID 30MG CAPSULES / 1 po qd